RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-5
BEHAVIORAL HEALTH UNITS IN NURSING FACILITIES

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1200-8-5-.01 SPECIAL SERVICES: Behavioral Unit pilot program. Structurally distinct parts of a nursing home may be designated as special care units for patients with dementia, cognitive disorders, psychiatric disorders, post-traumatic stress disorders, mania, schizophrenia, major depression, and mood disorders. These conditions result in certain behaviors that require daily behavior management programs and/or pharmacological interventions that cannot be managed in a less restrictive setting. The unit shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining the highest practicable level of physical, affective, behavioral and cognitive functioning. Units which hold themselves out to the public as providing specialized behavior services shall comply with provisions T.C.A. 68-11-1404 and shall be in compliance with the following minimum standards:

(1) In order to be admitted to the Behavioral Unit:

(a) A diagnosis of one or more of the above mentioned conditions must be made by a physician. The specific etiology causing the behavior shall be identified to the best level of certainty prior to admission to the special care unit; and,

(b) The need for admission must be determined by an interdisciplinary team consisting of at least a physician experienced in the management of the patients with these diagnoses, mental health professional, a registered nurse, and a relative, guardian, or patient care advocate on behalf of the patient.

(2) All patients qualifying for admission to the Behavioral Unit, regardless of payer source, shall be classified in the following RUGs categories: BA1; BA2; BB1; BB2; CA2; CB1; CB2; CC1; CC2; IA1; IA2; IB1 and IB2. Patients classified in the above categories have behavioral problems, are clinically complex, or have impaired cognition.

(3) Behavioral Units shall be separated from the remaining portion of the nursing home by a locked door and must have extraordinary and acceptable fire safety features and policies, which ensure the well being and protection of the patients.

(4) The patients must have direct access to a secured, therapeutic outdoor area. This outdoor area shall be designed and maintained to facilitate emergency evacuation.

(5) There must be limited access to the designated unit so that visitors and staff do not pass through the unit to get to other areas of the nursing home.

(6) Each unit must contain a designated dining/activity room, which shall accommodate 100 percent seating for the patients.

(7) Corridors or open spaces shall be designed to facilitate ambulation and activity, and shall have an unobstructed view from the central working or nurses' station.

(Rule 1200-8-5-.01, continued)

(8) Increased assistance with maintaining nutritional needs must be provided, with focus on frequent carbohydrate and protein snacks, nutritious finger foods, and extra fluids with increased vitamins, minerals and electrolytes.

(9) There must be assessment procedures to document behaviors, interventions, and effectiveness of behavior management and/or medication.

(10) New MDS at least every 180 days or at time of significant change is required, in order to determine if patient can move to Level I care.

(11) The Behavioral Unit shall have a structured, therapeutic activities program daily.

(12) The designated unit shall provide a minimum of 3.5 hours of direct care to each patient every day, including .75 hours of licensed nursing personnel time. Direct care shall not be limited to nursing personnel time and may include direct care provided by dietary staff, social workers, administrator, therapists, activities, psychiatric services, and other caregivers, including volunteers.

(13) A physician who has specialized training and experience in the care of individuals with severe behavioral conditions shall be responsible for the medical direction and medical oversight of the Behavioral Unit. He/she shall assist with the development and evaluation of policies and procedures governing the provision of medical service in the unit.

(14) A clinical psychologist with at least one-year of training shall be available on staff or a consulting basis to work with the patients and the unit.

(15) A transfer agreement with an acute psychiatric care facility is required and the Behavioral Unit patient has priority readmission status to the unit as his or her condition may warrant.

(16) In addition to the classroom instruction required in the nurse aide-training program, each nurse aide assigned to the unit shall have 40 additional hours of classroom instruction. This program shall include instruction in the following subject areas:

(a) Dealing with dysfunctional behavior and catastrophic reactions in the patient;

(b) Identifying and alleviating safety risks to the patient;

(c) Providing assistance in the activities of daily living for the patient;

(d) Communicating with the families and other persons interested in the patient;

(e) Charting and measuring behavior; and

(f) Behavior intervention techniques.

(17) Each patient shall have a treatment plan developed by facility staff that shall be reviewed monthly and implemented by an interdisciplinary treatment team consisting of at least a physician experienced in the management of the patients with these behaviors, a registered nurse, a social worker, psychiatric professional, activity coordinator, and a relative, guardian, or patient care advocate for the patient.

(18) A protocol for identifying and alleviating job stress among staff on the special care unit must be developed, implemented, and administered.

(19) The staff of the unit shall organize a support group for families of unit patients and non-patients from the community which meets at least quarterly for the purpose of:

(Rule 1200-8-5-.01, continued)

(a) Providing ongoing education for the families;

(b) Permitting families to give advice about treatment for patients and non-patients;

(c) Alleviating stress in family members; and

(d) Resolving special problems of unit patients and non-patients.

(20) When the interdisciplinary team determines that discharge of a patient to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the patient's family and caregiver in the transition to the new setting.

(21) Program staff shall be available post-discharge, for a period not to exceed thirty days, on a fee for service basis to act as a continuing resource for the patient, family or caregiver. The fees charged for transitional services shall be in addition to the facility's normal reimbursement for Behavioral Unit patients. However, the fee shall not exceed the facility's cost of providing the transitional service.

(22) Program staff shall be available for consultative services to community-based groups that provide behavioral health programs. The facility should serve as a community resource for treatment advice and clinical training. The fees charged for consultative services shall be in addition to the facility's normal reimbursement for Behavioral Unit patients. However, the fee shall not exceed the facility's cost of providing the consultative service.

(23) The facility shall create a marketing plan describing the community services to be provided, method of advertisement, and cost. Marketing plans and promotional materials are to be approved by the Bureau of TennCare no less than annually.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, and 68-11-209.* ***Administrative History:*** *Original rule certified May 31, 1984. Amendment filed May 22, 1986; effective June 21, 1986. Repeal filed March 18, 2000; effective May 30, 2000. New rule filed October 15, 2002; effective December 29, 2002.*

1200-8-5-.02 THROUGH 1200-8-5-.04 REPEALED.

Authority: *T.C.A. §§68-11-201, 68-11-04, and 68-11-209.* ***Administrative History:*** *Original rule certified May 31, 1984. Amendment filed May 22, 1986; effective June 21, 1986. Repeal filed March 18, 2000; effective May 30, 2000.*

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Authority: *T.C.A. §§56-4102 (D) and 56-4102 (E).* ***Administrative History:*** *Original rule filed February 5, 1975; effective March 7, 1985. Repeal filed May 22, 1986; effective June 21,1986.*